

Psychotherapy and Psychological Treatments: The Future

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Over the past 40 years the term *psychotherapy* has lost its ability to communicate the heterogeneous nature of our activities. There are at least two (and undoubtedly more) clearly delineated activities currently covered by this term. Going forward, it would resolve ambiguity and clarify objectives to delineate “psychological treatments” that are clearly compatible with the objectives of healthcare systems and “psychotherapy,” an equally valuable undertaking that primarily addresses problems in adjustment or growth. These two activities would not be distinguished on theory, technique, or even evidence, but on the problems addressed.

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Psychotherapy looks very different today than it did 30 to 40 years ago. From an era where there was at least a rough homogeneity in the process of psychotherapy if not the underlying theory (school), today the process is all but unrecognizable from one therapist to another. As a result, confusion and misunderstanding reign. In this brief overview, I will first describe what I sense is the current state and ambiguity that pervades the practice of “psychotherapy” in this modern era. Next, I will sketch out a vision that attempts to resolve this ambivalence and ambiguity by delineating (at least) two different approaches to therapy based not on theory, technique, or even evidence, but on presenting problems. These problems roughly coalesce into the categories of psycho-

pathology or pathophysiology versus adjustment and growth. Expanding on a theme briefly touched on before (Barlow, 2004, 2005) I refer to treatments addressing primarily pathology as “psychological treatments” and treatments addressing adjustment or growth as “psychotherapy.”

Before articulating these themes it is important to note that the tenets of evidence-based practice (EBP) have advanced rapidly to the point where they form core policy in most healthcare systems in the developed world, including mental health systems. Second, whereas little or no evidence existed on the effects of psychotherapy as measured by outcomes of reductions in psychopathology or improvements in functioning in previous eras, we now have a wealth of evidence on efficacy and effectiveness or clinical utility of treatment (Kazdin & Weisz, 2003; Nathan & Gorman, 2002; Roth & Fonagy, 2004; Smith, Kendall, & Keefe, 2002). In fact, from the point of view of psychotherapy or psychological treatments, the last 10 to 15 years have witnessed the appearance of literally hundreds of studies evaluating these treatments with the felicitous result that psychological treatments for many identified mental disorders and psychological aspects of physical disorders currently meet the stringent methodological criteria required to influence healthcare policy and practice. Thus, psychological procedures are beginning to be afforded the respect accorded to other interventions across the healthcare spectrum, such a medication and somatic treatments. In an era that is witnessing the first frontal assault of influence in healthcare systems around the world from the revolution of EBP, the existing evidence is either extremely useful or a bit disheartening depending on your point of view.

There are several reasons for this increased evidence. First, we have developed a much deeper understanding of the nature of physical and mental disorders in recent years, and this has directly resulted in the development of

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more precisely targeted interventions for both physical and mental disorders that address these newly delineated pathological features. Second, clinical research methodologies utilized to develop and evaluate new interventions have advanced substantially in the past 10 years, particularly in the size of clinical trials, data management procedures, and experimental design considerations to rule out confounding factors, such as “allegiance” effects. These design considerations are increasingly finding their way beyond “efficacy research” into what is referred to as “effectiveness” or “services” research where newly developed treatments are evaluated in frontline primary-care settings (e.g., Rollman et al., 2005; Roy-Byrne et al., 2005).

There are two additional interesting developments regarding these psychological treatments. First, as noted above, these procedures differ considerably from disorder to disorder in their content and implementation, a considerable departure from previous eras. In fact, this is very consistent with current clinical practice since few, if any, clinicians these days would believe that one could take exactly the same treatment approach to individuals presenting with, for example, trichotillomania, insomnia, irritable bowel syndrome, borderline personality disorder, or schizophrenia. Second, these treatments are derived from diverse theoretical approaches and there seems little question that, as evidence develops, traditional “schools” of psychotherapy will become less important with lines demarcating these schools becoming more and more fuzzy as evidence accumulates. Witness the example of “motivational interviewing” or “motivational enhancement therapy” for substance abuse (Burke, Arkowitz, & Mencola, 2003) that is derived from client-centered Rogerian techniques, and the recognition of implicit processes or the “unconscious” in cognitive-behavioral approaches.

Of course, debates continue about the relative contribution of “common factors” to these procedures (Baskin, Tierney, Minami, & Wampold, 2003; Huppert, Fabbro, & Barlow, 2006). Other debates focus on the relative potency of drugs and psychological treatments, as well as whether we should be paying more attention to heretofore untested procedures, or considering alternative diagnostic schemes (e.g., Crits-Christoph, Wilson, & Hollon, 2005; Weisz, Weersing, & Henggeler, 2005; Westen, Novotny, & Thompson-Brenner, 2004). As the data develop, more precise answers to these questions will be forthcoming.

However, all participants in these debates agree, by and large, that we should be focusing on integrating these procedures into the healthcare system and subjecting any treatments to empirical scrutiny and careful objective assessment.

But it seems to me that a deeper source of unease with the directions of EBP and the developing role of clinical psychology in emerging healthcare systems is evident, but has not been adequately articulated or addressed. Furthermore, the issues that have been raised (outlined below) are important and serious ones that deserve full consideration, but are not currently receiving that consideration due to the ambiguity with which the arguments are presented.

One sign of this unease is the rather unfocused concern that EBP represents the “medical model” with the implication that this is inherently a bad thing. In psychology, of course, this reflects a long-standing tradition of objecting to things medical harking back to a time when the profession of clinical psychology was fully and totally controlled by the medical establishment. In that era, the independent practice of psychotherapy in any organized healthcare setting was proscribed and psychologists could not be reimbursed for care in independent practice. Of course, this is no longer true. So what is the “medical model” that some individuals find so objectionable? In fact, the “medical model” itself is a loose and shifting metaphor that seems to mean at least three things. Earlier on, it referred to something like the “germ theory” of etiology that today could be translated into reductionistic and linear causal models of the development of psychopathology (“your disorder is due to a chemical imbalance”). But very few individuals these days, particularly outside the medical profession, would accept this simplistic modeling. Rather, most would adopt a more comprehensive biopsychosocial model (as does the author) recognizing the plasticity of brain function and gene expression, and the interacting influence of biological, psychological, and environmental factors in the production of psychopathology.

A second meaning of the medical model seems to refer to the proclivity among physicians to treat psychopathology medically; that is, to prescribe medication (or perhaps some alternative somatic therapies). Psychologists, of course, are generally ambivalent about the usefulness of pharmacological approaches to treatment, but it is now policy of

the American Psychological Association (APA) to seek prescription privileges so that, as a matter of policy, this particular aspect of the “medical model” is no longer objectionable. What seems to be left then is a general discomfort with being part of organized healthcare systems, including both the terminology and activities that are expected across these systems. Thus, some psychologists find themselves uncomfortable in many instances with terms such as “patient” (preferring client), “diagnoses,” and even “psychopathology.” Discomfort also exists when one is required to make a nomothetic diagnosis, indicate a “preferred” treatment based on best practice algorithms, and carefully measure outcomes as is currently required in most healthcare systems. This tension has been highlighted by the recent declaration of the APA that psychology is a healthcare profession (APA, 2001; Johnson, 2001), and the vigorous pursuit by the Practice Directorate of the APA of the inclusion of psychology in extant healthcare systems.

Difficulties with the “medical model” reflect, in my view, a much more fundamental issue, which goes to the very heart and soul of one’s conception of the psychotherapeutic process. This conception has been eloquently explicated many times, but I will choose as one example a recent op-ed contribution to *The New York Times* entitled “A Mind Is a Terrible Thing to Measure” to exemplify this conception (Phillips, 2006) because the author, Adam Phillips, states the issue clearly and succinctly. Here he says that psychotherapy is having yet another identity crisis. He notes that Western societies have been “... divided between religious truth and scientific truth,” and while none of the new psychotherapies are trying to prove they are genuine religions, perhaps psychotherapy should “... inhabit the middle ground of arts, in which truth and usefulness have traditionally been allowed certain latitude (nobody measures Shakespeare or tries to prove his values).” He goes on to say, “... one of the good things psychotherapy can do, like the arts, is to show us the limit of what science can do for our welfare. The scientific method alone is never going to be enough, especially when we are working out how to live and who we can be.” And finally, “... the attempt to present psychotherapy as a hard science ... is a sign of a misguided wish to make psychotherapy ... respectable.”

I believe Phillips is absolutely correct in most of what he says. As I have noted elsewhere, the search for personal

truth (and perhaps a little beauty) is a very noble undertaking with a history going back thousands of years to a time when Socrates stated that “an unexamined life is not worth living” (as recorded by Plato [360 BC/1996] in his *Apology*, 38a). In and of itself, this goal is respectable, and should not have to be matched up against criteria for EBPs in healthcare systems to achieve respectability. It is a different goal. But the basic error in these arguments is to equate this goal of psychotherapy with a goal of remediating or preventing pathology, either physical or psychological, in the context of an evidence-based healthcare system. To paraphrase another colleague lamenting recent developments: how could a therapist put a Jungian approach with large doses of attachment theory and feminist sensibilities on some list of approved treatments? Well, it would be difficult indeed since any healthcare system would want to know what it is you were treating and what objective measures you were using to assess outcomes. This point of view has also been very well articulated in an article by Kirk Schneider (1998) titled “Toward a Science of the Heart.” Citing Farley, he advocates romanticism and “... a psychology of meaning in the broadest sense placing the mystery of life in context and, most importantly, showing the road to generosity and love.”

One could make a convincing argument that by far the larger market for the services of those delivering psychotherapy would be for the promotion of better adjustment, resolution of problems in living, working out relationships, learning how to love and be loved, and personal growth. In fact, these very humanistic approaches, occupying “the middle ground of arts,” would make an excellent year long offering in a college of liberal arts.

Thus, I am suggesting that going forward we delineate (at least) two kinds of psychotherapy. One is placed firmly within our emerging healthcare systems so that psychological services will occupy an ever increasing role in these systems to the benefit of all. In fact, we have been extraordinarily successful so far in demonstrating the worth of what we do. I have suggested (Barlow, 2004) that these approaches be called “psychological treatments” to further underscore the central role of psychologists’ participation in these systems.

Second, for those noble, distinguished, and traditional efforts to enhance the process of living and the quality

and value of relationships, as well as promote adjustment and personal growth, we would have a second approach that retains the traditional name well accepted by many, “psychotherapy.” These two approaches would *not* be distinguished necessarily on the basis of theoretical schools, techniques, or even evidence, but rather on the problem addressed. For example, approaches currently outside of the healthcare system, which are “empirically supported treatments” with well-worked-out objective measurement systems such as “couple therapy” or “marital therapy” (Gottman, 1999; Wheeler, Christensen, & Jacobson, 2001), would not ordinarily meet current definitions of health care unless they were directed at accompanying psychopathology such as mood disorders. In any case, those problems and disorders that clearly are to be covered in our healthcare systems will be addressed by psychological treatments. Working out “how to live and who we can be” would be addressed by psychotherapy. Others have made this distinction using somewhat different terms, such as “life enhancement” instead of psychotherapy (Kendall, 1998; Kendall & Norton-Ford, 1982).

Of course, this dichotomy is overly general and simplistic as stated. First, healthcare systems are still debating what disorders and problems should be included and this has resulted in some pitched political battles focused recently on such issues as whether to reimburse for treatment or prevention of obesity. Even disorders widely accepted in systems of nosology are not gaining entry into the healthcare system as part of recent parity legislation if they are not seen as “severe” enough or “biologically based.” These battles are currently playing out both federally and state by state. Furthermore, we know that “subclinical” conditions are a substantial risk factor for later disorders (Barlow, 2002), and any reasonable healthcare system must include adequate preventive techniques along with remedial treatments, begging the question of how best to approach and address risk factors.

These are clearly controversial recommendations. But it seems it is time we come to grips with the fact that the term “psychotherapy” has lost its ability to communicate the heterogeneous nature of our activities; recognizing each activity for what it is would resolve ambiguity and confusion, avoid unnecessary constraints such as overly quantitative approaches to “measuring the mind,” and strengthen both approaches.

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